

No marked involvement of bladder or rectum till the end.

Usually terminates in dementia.

During the progress of the disease there may be paralysis of various cranial nerves.

Dr. Hamilton says: "From an inspection of this table, it will be evident that there is a close similarity between the symptoms of the two diseases, which I think may be explained by the difference of location. In both, defective co-ordination is marked. In both reflex action is lost. In both there may be tremor. In one the disease is an evidence of lesions in the cortex; in the other, in the white or gray matter of the cord. Both may be seen in the same individual, and after death the lesions are the same. The mental symptoms may be identical, though always differing in the period of appearance. Ocular difficulties may be present in either, as may difficulties in speech. Both are progressive, and generally fatal.

Generally obstinate constipation; sometimes paralysis of both sphincters.

No mental decay as a rule. Patient dies of phthisis.

Not uncommonly the fifth, sixth, third, and optic nerves may be affected.

**HUMORAL ALTERATIONS IN LOCOMOTOR ATAXIA.**—M. Bouchard called the attention of the Soc. de Biologie at its session of June 3d, (rep. in *Le Progres Médical*) to certain humoral alterations in locomotor ataxia. The saliva sometimes presents a very pronounced acidity, which gives rise to a characteristic alteration of the teeth. A groove forms in the tooth, at its junction with the gums, which gradually becomes deeper and deeper. M. Bouchard has also observed very interesting uropoietic disorders, in a man in the first stages of locomotor ataxia, and suffering from attacks of intense gastric disturbance. Some days before the attacks, the urine diminished in quantity and became albuminous; being very poor in urea. The gastric phenomena appeared, the urine remained albuminous, then the crisis past, the polyuria appeared, urea returned to its normal figure and the albumen disappeared in the urine.

Theoretically the establishment of the relation of cause and effect might be attempted, between the urinary alterations and the vomitings, but M. Bouchard would not pronounce on this point.

**TRAUMATIC MENINGITIS.**—Bergmann, *Samml. klin. Vorträge*, No. 101, (Abstr. in *St. Petersburg Med. Wochenschr.*).

The author, in connection with a series of illustrative cases, goes into an analysis of the symptoms of traumatic meningitis. These vary according to the seat of the lesion, and support, on the whole, the usual distinction made between meningitis of the base and that of the convexity of the brain. Meningitis of the convexity is immediately associated with wounds of the brain and the membranes, and secondarily with injuries of the bones of the arch of the skull, and is characterized by a progressive paralysis of the half of the body opposite to the wound, occurring between the third and the fifteenth days after the reception of

the injury. The successive involvement of motor functions, which have usually been attributed to encephalitis, under the name of "local symptoms," are also met with in meningitis without red softening, and are due to the paralysis of the motor centres demonstrated by Fritsch and Hitzig, in the cerebral cortex, the nutrition of which is probably affected by the inflammation of the very intimately connected pia-mater.

The symptoms of basilar meningitis are apparently quite different from those of the above described form. It arises from injury of the base of the skull, and has a tendency rather to involve the envelopes of the cord, than to ascend toward the vortex. Paralysis is absent, or is limited to the regions innervated by the cranial nerves; but with the implication of the cervical cord, the symptom of stiffness of the cervical muscles is met with. The diagnosis is often rendered difficult by reason of the severity of the injury of the head, and the quickly following long affections.

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**LEAD PARALYSIS.**—The following is a *résumé* of a communication made to the Soc. de Biologie, July 1, as reported in *Le Progrès Médical*.

1. Saturnine paralysis may commence either in the extensor of the little or the index finger.

2 The muscles of both hands may be equally paralyzed in painters.

3. The muscular contractility may progressively disappear in the various bundles of the deltoid.

4. The short extensor of the thumb frequently preserves its proper contractility after the other muscles are paralyzed.

5. The biceps are sometimes paralyzed.

6. The loss of electric contractility may precede that of muscular contractility.

7. When the muscles of the posterior face are paralyzed or atrophied, the electric current passes with the greatest facility in the flexor muscles.

8. There exists a saturnine hemiplegia.

9. Chronic lead poisoning may engender other cerebral disorders, choreic movements, ataxia, tremors, etc., susceptible of being cured.

10. Mercury can produce paralysis, exactly like those from lead, as has been demonstrated by M. Gubler.

11. Saturnine colic, according to M. Gubler, has its seat in the intestinal walls; in fact, we cannot cause pain by pressure on the abdominal muscles alone, while if we press on the intestines we cause one that is unbearable. Muscular pain of the abdominal walls may exist in the subjects of lead colic; we have made it disappear with the greatest facility, by electrization, as in the case of the ordinary myosalgia; M. Gubler has likewise observed this.

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**TRANSITORY ALBUMINURIA IN DELIRIUM TREMENS.**—Weinberg, *Berliner klin. Wochenschr.*, calls attention to the temporary albuminuria noticed in delirium tremens. He has observed it in 33 per cent. of the cases under his care at the Hamburg general hospital, and in eleven cases he has satisfactorily ascertained that it coincided in its appearance and its cessation with the delirium, beginning with a mere trace of albu-